SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*38876*
Company Tracking Number:	*164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*164016-AR - Application for Accident and Health Insurance*		
Project Name/Number:	*164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance*		

Filing at a Glance

Company: Combined Insurance Company of America

Product Name: 164016-AR - Application for Accident and Health Insurance	SERFF Tr Num: CMBD-125630654	State: ArkansasLH
TOI: H02I Individual Health - Accident Only	SERFF Status: Closed	State Tr Num: 38876
Sub-TOI: H02I.000 Health - Accident Only	Co Tr Num: 164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Deborah Shortridge	Disposition Date: 06/04/2008
	Date Submitted: 05/06/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 164016-AR - Application for Accident and Health Insurance	Status of Filing in Domicile: Not Filed
Project Number: 164016-AR - Application for Accident and Health Insurance	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/04/2008	
State Status Changed: 06/04/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

Please see attached cover letter

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*38876*
Company Tracking Number:	*164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE*		
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Product Name:	*164016-AR - Application for Accident and Health Insurance*		
Project Name/Number:	*164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance*		

Company and Contact

Filing Contact Information

Deborah Shortridge, Senior Policy Analyst
1000 Milwaukee Avenue
Glenview, IL 60025

Deborah_Shortridge@aon.com
(847) 953-1534 [Phone]
(847) 953-1557[FAX]

Filing Company Information

Combined Insurance Company of America
1000 Milwaukee Avenue
Glenview, IL 60025
(847) 953-1531 ext. [Phone]

CoCode: 62146
Group Code: 317
Group Name:
FEIN Number: 36-2136262

State of Domicile: Illinois
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	IL - $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Combined Insurance Company of America	$50.00	05/06/2008	20113905

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/04/2008	06/04/2008
Approved-Closed	Rosalind Minor	05/07/2008	05/07/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Application for Accident and Health Insurance	Form	Deborah Shortridge	06/04/2008	06/04/2008
6-04-08 Filing Letter	Supporting Document	Deborah Shortridge	06/04/2008	06/04/2008

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
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Disposition

Disposition Date: 06/04/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
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Project Name/Number:	*164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Readability Certification	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Variable Memorandum	Approved-Closed	Yes
Supporting Document	6-04-08 Filing Letter	Approved-Closed	Yes
Form *(revised)*	Application for Accident and Health Insurance	Approved-Closed	Yes
Form	Application for Accident and Health Insurance	Withdrawn	No

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*38876*
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Disposition

Disposition Date: 05/07/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

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Amendment Letter

Amendment Date:

Submitted Date: 06/04/2008

Comments:

Please see attached cover letter dated 6-04-08.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
164016-AR	Application/Enrollment Form	Application for Accident and Health Insurance	Initial				50	164016-AR.pdf

Supporting Document Schedule Item Changes:

User Added -Name: 6-04-08 Filing Letter

Comment:

6-04-08 - Filing Letter 164016-AR.pdf

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*38876*
Company Tracking Number:	*164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE*		
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Form Schedule

Lead Form Number: 164016-AR - Application for Accident and Health Insurance

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	164016-AR	Application/ Enrollment Form	Application for Accident and Health Insurance	Initial		50	164016-AR.pdf

COMBINED INSURANCE COMPANY OF AMERICA
5050 Broadway, Chicago, Illinois 60640
I apply for a policy based on the following information.

5001164016

APPLICATION NUMBER 5 0 0 1

Section 1 – BASIC INFORMATION *(Required for all products.)*

LANGUAGE PREFERENCE X E X S X F

M X F X INSURED'S FIRST NAME | MIDDLE INITIAL | LAST NAME

INSURED'S RESIDENCE ADDRESS | RESIDENCE PHONE NUMBER

CITY | STATE | ZIP

INSURED'S DATE OF BIRTH (M M D D Y Y Y Y) | INSURED'S AGE | CALL TYPE ADDRESS X Home X Business | REF/LINK POLICY NUMBER

INSURED'S BILLING ADDRESS IF DIFFERENT FROM RESIDENCE | SOCIAL SECURITY NUMBER

CITY | STATE | ZIP

Is any person applying for coverage on Medicaid? X YES X NO **Will this policy replace any existing policies?** X YES X NO

An Authorized Interviewer may call to obtain additional information required to complete this application. Check most convenient place and time to call:

X Home X Business ( ) _____ X Additional No. (Cell) ( ) _____

X 6:30 am - 8:00 am X 8:00 am - 12:00 pm X 12:00 pm - 3:00 pm X 3:00 pm - 6:00 pm X After 6:00 pm

(Required for Income Protector and optional for other coverages.)

INSURED'S BUSINESS NAME | BUSINESS PHONE NUMBER

INSURED'S BUSINESS ADDRESS

CITY | STATE | ZIP

(Required if Payor different from Insured.)

PAYOR'S FIRST NAME (IF OTHER THAN INSURED) | MIDDLE INITIAL | LAST NAME

PAYOR'S RESIDENCE ADDRESS (IF OTHER THAN INSURED)

CITY | STATE | ZIP

(Required for Critical Care Protector.)

BENEFICIARY'S FULL NAME (IF REQUIRED) | RELATIONSHIP TO INSURED

Section 2 – EMPLOYMENT & INCOME INFORMATION *(Required if applying for Income Protector only.)*

1. Insured's Occupation
2. Please describe all employment duties performed in detail:
3. I certify that my gross annual earnings, or net earnings if self-employed, at time of application (without overtime, unless overtime is contractual, and without other bonuses or incentives) is: $,
4. Are you self employed or have you been working for the same employer for less than 6 months? (A telephone interview may be required.) . . . . . Yes X No X
5. Do you currently work in your primary occupation, performing all primary duties, and work at least 30 hours or more per week? Yes X No X
6. Do you currently have any other in force disability coverage with another carrier? Yes X No X

Section 3 – UNDERWRITING INFORMATION *(Required for Income Protector and Critical Care Protector only.)*

INSURED'S HEIGHT FT. IN. INSURED'S WEIGHT LBS. INSURED'S DRIVERS LICENSE STATE

	Insured Yes	Insured No
1. Has the insured received any medical ADVICE or TREATMENT from a member of the medical profession, or taken any prescription MEDICINE within the past 5 years for:		
a. Angina, stroke, heart attack, atrial fibrillation, congestive heart failure, or a heart valve replacement?	X	X
b. Liver or kidney disorder, cirrhosis of the liver, or organ transplant?	X	X
c. Cancer, melanoma, brain tumor, Hodgkin's disease or leukemia?	X	X
d. Alzheimer's disease, dementia, Parkinson's disease, Multiple Sclerosis?	X	X
e. Chronic Obstructive Lung/Pulmonary disease, Emphysema or other lung disease requiring oxygen?	X	X
f. Manic depression, schizophrenia, alcoholism or drug addiction?	X	X
2. Is the insured listed on this application for insurance an insulin dependent diabetic?	X	X
3. Is the insured listed been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)?	X	X
4. Has the insured been convicted of reckless driving or driving under the influence of alcohol within the past 5 years?	X	X
5. Is the insured currently on Disability? (excluding Military Disability)	X	X
If any of the above questions are answered "Yes", the insured is not eligible for coverage.		
6. Has the insured applied for or received Disability Benefits (including that from Worker's Compensation, Social Security or Military Disability) within the last 12 months?	X	X
7. Is the insured listed on the application for insurance a non-insulin dependent diabetic taking oral medication and/or treated by diet? **(A "Yes" answer when applying for Income Protector disqualifies applicant.)**	X	X
8. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for an injury, disease or disorder of the back, neck, spine, or joint?	X	X
9. Have 2 or more of the insured's parents, brothers or sisters been diagnosed with heart disease, cancer, or any malignant growths while they were under the age of 60?	X	X
10. Within the past 5 years have you had any medical advice, diagnostic tests or treatment from a member of the medical profession or taken any prescription medications for any other medical condition(s) not listed above, excluding flu, colds and routine physicals? **(If "Yes" is answered to question 6, 7, 8, 9 or 10 explain below.) In any case, please provide information on your physician.**	X	X

Based on your answers to the above health questions and/or evaluation of your application an exclusionary rider for specific medical conditions, and avocational activities may be added to your Income Protector policy.

Health Condition	Medication/Dosage	Treatment?		Surgery?		Dates	Physician(s) Name: Address (Street, City, State, Zip) & Phone
		X Yes	X No	X Yes	X No		
		X Yes	X No	X Yes	X No		
		X Yes	X No	X Yes	X No		

Section 4 – PLAN SELECTION

FORM NUMBER | PLAN CODE

X **Accident Protector** 14028 ASP

X **Accident & Sickness Protector**

X Individual X Silver (Plan I)
X Individual/Spouse X Gold (Plan II)
X Single Parent
X Family

If applying for Accident/Sickness, the following qualifying question must be answered:

Qualification Question – Read Carefully: To the best of your knowledge and belief, have you or any eligible dependent listed below had any advice or treatment for cancer, diabetes, stroke, heart attack, or other heart condition within the last five (5) years?

Insured: X Yes X No Spouse: X Yes X No Children: (Answer for each eligible child below)

X **Cancer Care Protector** FORM NUMBER 16075 PLAN CODE CAP

X Individual Plan X Silver (Plan I)
X Family Plan X Gold (Plan II)
X Platinum (Plan III)

Qualification Question – Read Carefully: To the best of your knowledge and belief, have you or any eligible dependent listed below had any advice or treatment for cancer, or skin cancer within the last ten (10) years?

Insured: X Yes X No Spouse: X Yes X No Children: (Answer for each eligible child below)

X **Critical Care Protector**

FORM NUMBER 16521 | PLAN CODE CCP | AMOUNT OF INSURANCE $,

Paid Up Rider X YES X NO 20 Years

Has the insured used tobacco products in any form in the last 12 months? Insured: X YES X NO

X **Income Protector**

FORM NUMBER 19819 | PLAN CODE DI1 | Monthly Benefit $,

Benefit Period: X 06 months X 01 year X 02 years

Elimination Period: X 14 X 30 X 90 days

Occupation Class

Section 5 – PREMIUM & BILLING INFORMATION *(Required for all products.)*

RENEWAL MODE: X ANNL. X S.A. X MO. X TPP

X Please charge or debit my checking account monthly.

Preferred Billing Date

TOTAL MODAL PREMIUM $.

Section 6 – DEPENDENT INFORMATION

(Required if applying for Dependent Coverage Accident & Sickness, Cancer Care Protector).

X Male
X Female

SPOUSE'S FIRST NAME | MIDDLE INITIAL | LAST NAME | SPOUSE'S DATE OF BIRTH MM DD YYYY

Child's Name (First Initial Last)	Birthdate: Mo/Day/Yr	Qualification Question Y	N	Child's Name (First Initial Last)	Birthdate: Mo/Day/Yr	Qualification Question Y	N
	MM D D Y Y	X	X		MM D D Y Y	X	X
	MM D D Y Y	X	X		MM D D Y Y	X	X
	MM D D Y Y	X	X		MM D D Y Y	X	X

APPLICATION NUMBER 5 0 0 4

5004164016

Section 7 – DECLARATIONS – This section must be read, signed, and dated by Insured.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.

In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, Notice of Information Practices, and (if applicable) Outline of Coverage.
3. If applying for an Accident Only policy, I understand that the policy does not provide benefits for loss from sickness.
4. If applying for Critical Care Protector, I understand that the policy: 1) is NOT major medical and NOT meant to replace medical expense insurance; and 2) is NOT life insurance; and I am not covered by any Title XIX program (Medicaid or any similar name).
5. If applying for the Cancer Care Protector Policy, I understand that the policy is cancer only and does not pay benefits for loss from any other sickness or from accidents. FOR PERSONS ELIGIBLE FOR MEDICARE: I acknowledge receipt of the "Guide to Health Insurance" and duplication notice.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB) or consumer reporting agency or through a personal telephone interview to release to Combined Insurance Company of America any information regarding the insured, or past or present health of the insured for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the date of application. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to the Company.

You may revoke this authorization anytime by writing Combined; however, such revocation may affect coverage.

Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I authorize Combined to show my name as a policyholder to prospective insureds. X YES X NO

X _____ Date of Application: M M D D Y Y Y Y

Signature of Insured

City (where signed): _____ State: _____

I, the authorized agent/producer, have on the Date of Application recorded the information as given to me. I have delivered the Notice of Information Practices, and where applicable, the Outline of Coverage. I have no knowledge of any unfavorable medical history not recorded on this Application. I certify that I have inspected this application for completeness and according to our field underwriting guidelines it may be submitted to the Home Office for further underwriting review.

Licensed Agent/Producer _____ (print)

Agent's/Producer's Signature _____ Code # _____

Sales Manager _____ (print)

Manager's Signature _____ Code # _____

Date M M D D Y Y Y Y

Primary Agent/Producer contact information

Agent's/Producer's phone
Agent's/Producer's e-mail address
Agent's/Producer's cell phone

Home Office use only

Complete this area when splitting commissions.	
Primary	Secondary
Agent/Producer Name	Agent/Producer Name
Code #	Code #
Percentage	Percentage
Agent's/Producer's Signature	Agent's/Producer's Signature

5005164016

APPLICATION NUMBER 5005

AUTOMATIC PREMIUM COLLECTION
(Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: City: State:

BANK ROUTING NUMBER

BANK ACCOUNT NUMBER

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Complete if adding policies from another application

Charge my Checking X Savings X Initial Premium Collected $

Policy Type → (L = Life, H = Health)

Preferred Billing Date

AUTHORIZATION FOR ELECTRONIC DEBIT

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule.

I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Signature of Payor Date: MM DD YYYY

Amount of Insurance	$

COMBINED INSURANCE COMPANY OF AMERICA • 5050 N. Broadway • Chicago, Illinois 60640

CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY

Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.

Conditions Which Must Be Satisfied Before Coverage Is Effective:

If both of the following conditions for any person proposed to be insured in the application are satisfied:

1. The first premium has been paid with the application; and
2. The Company, upon investigation, is satisfied that on the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for;

Effective Date of Coverage:

then, if both of the above conditions are satisfied, the insurance applied for on such person shall take effect on the date of application.

Limitation of Certain Coverage:

Provided that in the event of death of the Proposed Insured prior to issuance of the policy(ies) such insurance applied for under the application is limited to $50,000 as a lump sum under each policy, or if a monthly income policy, monthly payments may not exceed a total of $50,000 under each policy.

If any of the above conditions are not met, the policy(ies) applied for will not take effect unless and until the first premium is paid and the policy is issued during such person's lifetime. In the event the application is declined, the payment shown on this receipt will be returned to the applicant. The application shall be deemed declined if the policy(ies) is (are) not issued within 60 days after the date of application.

Received from _____

$ _____ as First Full Premium.

For Form No(s). _____

☐ Annual

☐ Monthly Automatic Premium Collection

☐ Tailor Pay Plan

If any check, draft or money order given in payment of the premium is not honored, this receipt shall be void.

_____
Proposed Insured

_____ _____ _____
Date Authorized Agent/Producer Agent/Producer Code Number

5005164016

APPLICATION NUMBER 5 0 0 5

AUTOMATIC PREMIUM COLLECTION
(Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Complete if adding policies from another application

Charge my Checking X Savings X Initial Premium Collected $ Policy Type → (L = Life, H = Health)

Preferred Billing Date

AUTHORIZATION FOR ELECTRONIC DEBIT

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

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PAYOR'S PHONE NUMBER

X Signature of Payor Date: M M D D Y Y Y Y

Amount of Insurance	$

COMBINED INSURANCE COMPANY OF AMERICA • 5050 N. Broadway • Chicago, Illinois 60640

CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY

Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.

Conditions Which Must Be Satisfied Before Coverage Is Effective:

If both of the following conditions for any person proposed to be insured in the application are satisfied:

1. The first premium has been paid with the application; and
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Effective Date of Coverage:

then, if both of the above conditions are satisfied, the insurance applied for on such person shall take effect on the date of application.

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Received from _____

$ _____ as First Full Premium.

For Form No(s). _____

☐ Annual

☐ Monthly Automatic Premium Collection

☐ Tailor Pay Plan

If any check, draft or money order given in payment of the premium is not honored, this receipt shall be void.

_____
Proposed Insured

_____ _____ _____
Date Authorized Agent/Producer Agent/Producer Code Number

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*38876*
Company Tracking Number:	*164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE*		
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Product Name:	*164016-AR - Application for Accident and Health Insurance*		
Project Name/Number:	*164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*38876*
Company Tracking Number:	*164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*164016-AR - Application for Accident and Health Insurance*		
Project Name/Number:	*164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 05/07/2008
Comments:
Attachment:
Certification of Compliance.pdf

Bypassed -Name: Application
Review Status: Approved-Closed 05/07/2008
Bypass Reason: Not applicable, filing an application for approval
Comments:

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 05/07/2008
Bypass Reason: Not Applicable, filing an application.
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 05/07/2008
Bypass Reason: Not Applicable, filing an application.
Comments:

Satisfied -Name: Readability Certification
Review Status: Approved-Closed 05/07/2008
Comments:
Attachment:
164016 flesch score.pdf

Satisfied -Name: Cover Letter
Review Status: Approved-Closed 05/07/2008
Comments:
Attachment:
164016 Cover Letter.pdf

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*38876*
Company Tracking Number:	*164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*164016-AR - Application for Accident and Health Insurance*		
Project Name/Number:	*164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance*		

Satisfied -Name: Variable Memorandum

Review Status: Approved-Closed 05/07/2008

Comments:

Attachment:

Variable Memorandum.pdf

Satisfied -Name: 6-04-08 Filing Letter

Review Status: Approved-Closed 06/04/2008

Comments:

Attachment:

6-04-08 - Filing Letter 164016-AR.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Combined Insurance Company of America

Form Number(s): 164016-AR - Application for Accident and Health Insurance

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Michael J. Hollar
Name

Assistant Secretary
Title

May 6, 2008
Date

COMBINED
INSURANCE
1000 Milwaukee Avenue, Glenview, Illinois 60025

READABILITY CERTIFICATION

RE: Form No. 164016-AR – Application for Accident & Health Insurance Coverage

We hereby certify that the above captioned form has a Flesch Index Score of 50 and meets the reading ease requirements.

Michael J. Hollar
Assistant Secretary

Michael J. Hollar – Assistant Secretary and Manager - Policy Filings/Government Relations
Toll Free 888.449.3623 Direct 847.953.1531 Fax 847.953.1557 E-Mail: Michael_Hollar@aon.com

COMBINED
INSURANCE
1000 Milwaukee Avenue, Glenview, Illinois 60025

VIA SERFF

May 6, 2008

Mr. Dan Honey
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

RE: **SERFF Tracking Number: CMBD-125630654**
Combined Insurance Company of America
FEIN Number 36-2136262
NAIC Number 317-62146
Form No. 164016-AR - Application for Accident & Health Insurance Coverage
164016-1H - Conditional Receipt
Individual Accident and Health

Dear Mr. Honey:

This is a new filing. Application 164016-AR is a new form which will not replace any existing applications. Application 164016-AR will be used with our previously approved accident and health forms (listed below) and is being filed as variable to allow it to be used with any future form filings. These forms are solicited on a face-to-face basis by our Insurance Producers or by direct market for telephone and mail solicitation.

Form No.	Description	Approval Date
14028-AR	Accident Only Policy	August 25, 2005
12400-AR	Sickness Only Rider	April 13, 2006
16075-AR	Cancer Only Policy	December 31, 1987
16521-AR	Specified Critical Condition Policy	February 27, 2002
16402	20 Year Paid Up Rider	February 27, 2002
19819-AR	Disability Income Policy	May 13, 1996
19423	Extended Benefits for Total Disability Rider	May 13, 1996

Please consider the arrangement of the information on the application as variable. The information may be rearranged to accommodate data processing or marketing needs but the information will remain the same. The variable bracketed areas are all inclusive; however, we may delete boxes, if necessary, based on our marketing decisions for the policy plans. A variable memorandum is attached.

Deborah Shortridge, HIA, DHP, DIA - Senior Policy Analyst - Policy Filings/Government Relations
Toll Free 888.449.3623 Direct 847.953.1534 Fax 847.953.1557 E-Mail: Deborah_Shortridge@combined.com

Also, enclosed are the following:

1. A $50 retaliatory filing fee has been submitted by EFT
2. Readability Certification
3. Certificate of Compliance

We appreciate your time in reviewing this filing. Please call me at our toll free number or email me if you have further questions or need additional information.

COMBINED INSURANCE COMPANY

Sincerely,

Deborah Shortridge

Deborah Shortridge, HIA, DHP, DIA
Senior Policy Analyst

Deborah Shortridge, HIA, DHP, DIA - Senior Policy Analyst - Policy Filings/Government Relations
Toll Free 888.449.3623 Direct 847.953.1534 Fax 847.953.1557 E-Mail: Deborah_Shortridge@combined.com

COMBINED INSURANCE
Combined Insurance Company of America
1000 Milwaukee Avenue • Glenview, Illinois 60025

Variable List for form 164016

Variable	Options
Page 1	
1. [Language Preference area]	All-inclusive. May be deleted if only offered in English or English/Spanish, or English/French.
[Social Security Number]	May be deleted if we decide not to use.
Page3	
2. [Form Number]	Bracketed to allow for a future change in the policy form number.
3. [Plan Code: ASP/CAP/CCP/DI1]	All-inclusive. May be deleted if we stop selling a policy.
4. Coverage and Plan Options	Bracketed to allow for us to remove or add to options without having to refile this application.
5. Income Protection Benefit	Amount of Insurance Benefit/Elimination Periods Will be Limited to the rating information approved in connection with the policies.
6. [Return of Premium/Paid Up Rider]	Yes and No box and modal premium amount to be deleted if we decide to market the CAP and CCS without the Riders.
7. Renewal Modes	Bracketed to allow for removal of a particular mode option.
8. Premium & Billing Information	All-inclusive. When system allows, applicant can choose date of billing and whether it is charged to the Saving or Checking account monthly. May be deleted.
9. Page 4 Please read carefully items 3,4, & 5. 3. If applying for an Accident Only Policy…" 4. If applying for a Critical Condition Protector…" 5. If applying for Cancer Protector…"	May be deleted if we stop selling the indicated policy.

Variable List for form 164016

10. [Home Office use only]	All-inclusive. May be deleted if we do not offer split commission.
11. [Automatic Premium Collection]	May be deleted if it is decided to have Automatic Premium Collection a separate document.
12. [Savings]	Bracketed to allow for removal of this deduction location option.
13. [Preferred Billing Date]	Bracketed to allow for removal of this deduction location option.

VIA SERFF

June 4, 2008

Ms. Rosalind Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

RE: **Combined Insurance Company of America**
FEIN Number 36-2136262
NAIC Number 317-62146
Form No. 164016-AR - Application for Accident & Health Insurance Coverage
164016-1H - Conditional Receipt
Individual Accident and Health

Dear Ms. Minor:

Attached is a substitute filing for the above captioned previously approval by your Department on May 7, 2008 under SERFF Tracking Number CMBD-125630654.

The form is identical to the form previously approved except for the following changes:

1. Changed Insured's Mailing address to Billing address;
2. Added call type address for home or business with check boxes;
3. Section 6 – Dependent Information added check boxes of Male or Female for Spouse.

No other changes, except as stated above, have been made. This form has not yet been made available for use or issued.

We appreciate your extending your approval to the enclosed forms. Please call me at our toll free number or email me if you have further questions or need additional information.

COMBINED INSURANCE COMPANY

Sincerely,

Deborah Shortridge

Deborah Shortridge, HIA, DHP, DIA
Senior Policy Analyst

Deborah Shortridge, HIA, DHP, DIA – Senior Policy Analyst – Policy Filings/Government Relations
Toll Free # 888.449.3623 Direct # 847.953.1534 Fax # 847.953.1557 Email: Deborah_Shortridge@combined.com

1000 N. Milwaukee Avenue • Glenview, Illinois 60025 • www.combinedinsurance.com
The ACE Group of Companies

SERFF Tracking Number:	*CMBD-125630654*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*38876*
Company Tracking Number:	*164016-AR - APPLICATION FOR ACCIDENT AND HEALTH INSURANCE*		
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Product Name:	*164016-AR - Application for Accident and Health Insurance*		
Project Name/Number:	*164016-AR - Application for Accident and Health Insurance/164016-AR - Application for Accident and Health Insurance*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Application for Accident and Health Insurance	05/06/2008	164016-AR.pdf

COMBINED INSURANCE COMPANY OF AMERICA
5050 Broadway, Chicago, Illinois 60640
I apply for a policy based on the following information.

5001164016

APPLICATION NUMBER 5 0 0 1

Section 1 – BASIC INFORMATION *(Required for all products.)*

LANGUAGE PREFERENCE X E X S X F

M X F X INSURED'S FIRST NAME | MIDDLE INITIAL | LAST NAME

INSURED'S RESIDENCE ADDRESS | RESIDENCE PHONE NUMBER

CITY | STATE | ZIP

INSURED'S DATE OF BIRTH (M M D D Y Y Y Y) | INSURED'S AGE

REF/LINK POLICY NUMBER

INSURED'S MAILING ADDRESS IF DIFFERENT FROM RESIDENCE | SOCIAL SECURITY NUMBER

CITY | STATE | ZIP

Is any person applying for coverage on Medicaid? X YES X NO **Will this policy replace any existing policies?** X YES X NO

An Authorized Interviewer may call to obtain additional information required to complete this application. Check most convenient place and time to call:

X Home X Business ( ) _____ X Additional No. (Cell) ( ) _____

X 6:30 am - 8:00 am X 8:00 am - 12:00 pm X 12:00 pm - 3:00 pm X 3:00 pm - 6:00 pm X After 6:00 pm

(Required for Income Protector and optional for other coverages.)

INSURED'S BUSINESS NAME | BUSINESS PHONE NUMBER

INSURED'S BUSINESS ADDRESS

CITY | STATE | ZIP

(Required if Payor different from Insured.)

PAYOR'S FIRST NAME (IF OTHER THAN INSURED) | MIDDLE INITIAL | LAST NAME

PAYOR'S RESIDENCE ADDRESS (IF OTHER THAN INSURED)

CITY | STATE | ZIP

(Required for Critical Care Protector.)

BENEFICIARY'S FULL NAME (IF REQUIRED) | RELATIONSHIP TO INSURED

Section 2 – EMPLOYMENT & INCOME INFORMATION *(Required if applying for Income Protector only.)*

1. Insured's Occupation
2. Please describe all employment duties performed in detail:
3. I certify that my gross annual earnings, or net earnings if self-employed, at time of application (without overtime, unless overtime is contractual, and without other bonuses or incentives) is: $,
4. Are you self employed or have you been working for the same employer for less than 6 months? (A telephone interview may be required.) . . . . . Yes X No X
5. Do you currently work in your primary occupation, performing all primary duties, and work at least 30 hours or more per week? Yes X No X
6. Do you currently have any other in force disability coverage with another carrier? Yes X No X

Section 3 – UNDERWRITING INFORMATION *(Required for Income Protector and Critical Care Protector only.)*

INSURED'S HEIGHT FT. IN. INSURED'S WEIGHT LBS. INSURED'S DRIVERS LICENSE STATE

	Insured Yes	Insured No
1. Has the insured received any medical ADVICE or TREATMENT from a member of the medical profession, or taken any prescription MEDICINE within the past 5 years for:		
a. Angina, stroke, heart attack, atrial fibrillation, congestive heart failure, or a heart valve replacement?	X	X
b. Liver or kidney disorder, cirrhosis of the liver, or organ transplant?	X	X
c. Cancer, melanoma, brain tumor, Hodgkin's disease or leukemia?	X	X
d. Alzheimer's disease, dementia, Parkinson's disease, Multiple Sclerosis?	X	X
e. Chronic Obstructive Lung/Pulmonary disease, Emphysema or other lung disease requiring oxygen?	X	X
f. Manic depression, schizophrenia, alcoholism or drug addiction?	X	X
2. Is the insured listed on this application for insurance an insulin dependent diabetic?	X	X
3. Is the insured listed been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)?	X	X
4. Has the insured been convicted of reckless driving or driving under the influence of alcohol within the past 5 years?	X	X
5. Is the insured currently on Disability? (excluding Military Disability)	X	X
If any of the above questions are answered "Yes", the insured is not eligible for coverage.		
6. Has the insured applied for or received Disability Benefits (including that from Worker's Compensation, Social Security or Military Disability) within the last 12 months?	X	X
7. Is the insured listed on the application for insurance a non-insulin dependent diabetic taking oral medication and/or treated by diet? **(A "Yes" answer when applying for Income Protector disqualifies applicant.)**	X	X
8. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for an injury, disease or disorder of the back, neck, spine, or joint?	X	X
9. Have 2 or more of the insured's parents, brothers or sisters been diagnosed with heart disease, cancer, or any malignant growths while they were under the age of 60?	X	X
10. Within the past 5 years have you had any medical advice, diagnostic tests or treatment from a member of the medical profession or taken any prescription medications for any other medical condition(s) not listed above, excluding flu, colds and routine physicals? **(If "Yes" is answered to question 6, 7, 8, 9 or 10 explain below.) In any case, please provide information on your physician.**	X	X

Based on your answers to the above health questions and/or evaluation of your application an exclusionary rider for specific medical conditions, and avocational activities may be added to your Income Protector policy.

Health Condition	Medication/Dosage	Treatment?		Surgery?		Dates	Physician(s) Name: Address (Street, City, State, Zip) & Phone
		X Yes	X No	X Yes	X No		
		X Yes	X No	X Yes	X No		
		X Yes	X No	X Yes	X No		

5003164016

APPLICATION NUMBER 5003

Section 4 – PLAN SELECTION

X **Accident Protector** FORM NUMBER 14028 PLAN CODE ASP

X **Accident & Sickness Protector**

If applying for Accident/Sickness, the following qualifying question must be answered:

X Individual X Individual/Spouse X Single Parent X Family

X Silver (Plan I) X Gold (Plan II)

Qualification Question – Read Carefully: To the best of your knowledge and belief, have you or any eligible dependent listed below had any advice or treatment for cancer, diabetes, stroke, heart attack, or other heart condition within the last five (5) years?

Insured: X Yes X No Spouse: X Yes X No Children: (Answer for each eligible child below)

X **Cancer Care Protector** FORM NUMBER 16075 PLAN CODE CAP

X Individual Plan X Family Plan

X Silver (Plan I) X Gold (Plan II) X Platinum (Plan III)

Qualification Question – Read Carefully: To the best of your knowledge and belief, have you or any eligible dependent listed below had any advice or treatment for cancer, or skin cancer within the last ten (10) years?

Insured: X Yes X No Spouse: X Yes X No Children: (Answer for each eligible child below)

X **Critical Care Protector**

FORM NUMBER 16521 PLAN CODE CCP AMOUNT OF INSURANCE $,

Paid Up Rider X YES X NO 20 Years

Has the insured used tobacco products in any form in the last 12 months? Insured: X YES X NO

X **Income Protector**

FORM NUMBER 19819 PLAN CODE DI1 Monthly Benefit $,

Benefit Period X 06 months X 01 year X 02 years

Elimination Period X 14 X 30 X 90 days

Occupation Class

Section 5 – PREMIUM & BILLING INFORMATION *(Required for all products.)*

RENEWAL MODE X ANNL. X S.A. X MO. X TPP

X Please charge or debit my checking account monthly.

Preferred Billing Date

TOTAL MODAL PREMIUM $.

Section 6 – DEPENDENT INFORMATION

(Required if applying for Dependent Coverage Accident & Sickness, Cancer Care Protector).

SPOUSE'S FIRST NAME | MIDDLE INITIAL | LAST NAME | SPOUSE'S DATE OF BIRTH (MM DD YYYY)

Child's Name (First Initial Last)	Birthdate: Mo/Day/Yr	Qualification Question Y	N	Child's Name (First Initial Last)	Birthdate: Mo/Day/Yr	Qualification Question Y	N
	MM D D Y Y	X	X		MM D D Y Y	X	X
	MM D D Y Y	X	X		MM D D Y Y	X	X
	MM D D Y Y	X	X		MM D D Y Y	X	X

APPLICATION NUMBER 5 0 0 4

5004164016

Section 7 – DECLARATIONS – This section must be read, signed, and dated by Insured.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application, the contract is issued, and the required premium is received by Combined Insurance Company of America.

In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
2. I have received the Medical Information Bureau (MIB) Disclosure Statement, the notice under the Fair Credit Reporting Act, Notice of Information Practices, and (if applicable) Outline of Coverage.
3. If applying for an Accident Only policy, I understand that the policy does not provide benefits for loss from sickness.
4. If applying for Critical Care Protector, I understand that the policy: 1) is NOT major medical and NOT meant to replace medical expense insurance; and 2) is NOT life insurance; and I am not covered by any Title XIX program (Medicaid or any similar name).
5. If applying for the Cancer Care Protector Policy, I understand that the policy is cancer only and does not pay benefits for loss from any other sickness or from accidents. FOR PERSONS ELIGIBLE FOR MEDICARE: I acknowledge receipt of the "Guide to Health Insurance" and duplication notice.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB) or consumer reporting agency or through a personal telephone interview to release to Combined Insurance Company of America any information regarding the insured, or past or present health of the insured for the purpose of evaluating this application for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the date of application. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to the Company.

You may revoke this authorization anytime by writing Combined; however, such revocation may affect coverage.

Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I authorize Combined to show my name as a policyholder to prospective insureds. X YES X NO

X _____ Date of Application: M M D D Y Y Y Y

Signature of Insured

City (where signed): _____ State: _____

I, the authorized agent/producer, have on the Date of Application recorded the information as given to me. I have delivered the Notice of Information Practices, and where applicable, the Outline of Coverage. I have no knowledge of any unfavorable medical history not recorded on this Application. I certify that I have inspected this application for completeness and according to our field underwriting guidelines it may be submitted to the Home Office for further underwriting review.

Licensed Agent/Producer _____ (print)

Agent's/Producer's Signature _____ Code # _____

Sales Manager _____ (print)

Manager's Signature _____ Code # _____

Date M M D D Y Y Y Y

Primary Agent/Producer contact information

Agent's/Producer's phone
Agent's/Producer's e-mail address
Agent's/Producer's cell phone

Home Office use only

Complete this area when splitting commissions.	
Primary	Secondary
Agent/Producer Name	Agent/Producer Name
Code #	Code #
Percentage	Percentage
Agent's/Producer's Signature	Agent's/Producer's Signature

5005164016

APPLICATION NUMBER 5005

AUTOMATIC PREMIUM COLLECTION
(Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: City: State:

BANK ROUTING NUMBER

BANK ACCOUNT NUMBER

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Complete if adding policies from another application

Charge my Checking X Savings X Initial Premium Collected $

Policy Type → (L = Life, H = Health)

Preferred Billing Date

AUTHORIZATION FOR ELECTRONIC DEBIT

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule.

I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Signature of Payor Date: MM DD YYYY

Amount of Insurance	$

COMBINED INSURANCE COMPANY OF AMERICA • 5050 N. Broadway • Chicago, Illinois 60640

CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY

Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.

Conditions Which Must Be Satisfied Before Coverage Is Effective:

If both of the following conditions for any person proposed to be insured in the application are satisfied:

1. The first premium has been paid with the application; and
2. The Company, upon investigation, is satisfied that on the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for;

Effective Date of Coverage:

then, if both of the above conditions are satisfied, the insurance applied for on such person shall take effect on the date of application.

Limitation of Certain Coverage:

Provided that in the event of death of the Proposed Insured prior to issuance of the policy(ies) such insurance applied for under the application is limited to $50,000 as a lump sum under each policy, or if a monthly income policy, monthly payments may not exceed a total of $50,000 under each policy.

If any of the above conditions are not met, the policy(ies) applied for will not take effect unless and until the first premium is paid and the policy is issued during such person's lifetime. In the event the application is declined, the payment shown on this receipt will be returned to the applicant. The application shall be deemed declined if the policy(ies) is (are) not issued within 60 days after the date of application.

Received from _____

$ _____ as First Full Premium.

For Form No(s). _____

☐ Annual

☐ Monthly Automatic Premium Collection

☐ Tailor Pay Plan

If any check, draft or money order given in payment of the premium is not honored, this receipt shall be void.

_____
Proposed Insured

_____ _____ _____
Date Authorized Agent/Producer Agent/Producer Code Number

5005164016

APPLICATION NUMBER 5 0 0 5

AUTOMATIC PREMIUM COLLECTION
(Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: City: State:

BANK ROUTING NUMBER

BANK ACCOUNT NUMBER

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Complete if adding policies from another application

Charge my Checking X Savings X Initial Premium Collected $

Policy Type → (L = Life, H = Health)

Preferred Billing Date

AUTHORIZATION FOR ELECTRONIC DEBIT

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule.

I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Signature of Payor Date: M M D D Y Y Y Y

Amount of Insurance	$

COMBINED INSURANCE COMPANY OF AMERICA • 5050 N. Broadway • Chicago, Illinois 60640

CONDITIONAL RECEIPT IMPORTANT READ CAREFULLY

Payment of Premium Does Not Provide Insurance Coverage Until All Conditions Specified Below Are Satisfied. Also Note Limitation On Coverage Specified Below.

Conditions Which Must Be Satisfied Before Coverage Is Effective:

If both of the following conditions for any person proposed to be insured in the application are satisfied:

1. The first premium has been paid with the application; and
2. The Company, upon investigation, is satisfied that on the date of this receipt shown below, such person was an acceptable risk according to the Company's rules and regulations for the plan and amount of insurance applied for;

Effective Date of Coverage:

then, if both of the above conditions are satisfied, the insurance applied for on such person shall take effect on the date of application.

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If any of the above conditions are not met, the policy(ies) applied for will not take effect unless and until the first premium is paid and the policy is issued during such person's lifetime. In the event the application is declined, the payment shown on this receipt will be returned to the applicant. The application shall be deemed declined if the policy(ies) is (are) not issued within 60 days after the date of application.

Received from _____

$ _____ as First Full Premium.

For Form No(s). _____

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If any check, draft or money order given in payment of the premium is not honored, this receipt shall be void.

_____
Proposed Insured

_____ _____ _____
Date Authorized Agent/Producer Agent/Producer Code Number